

# January 2014 Medicare HMO Plans Comparison

Benefit	KelseyCare Advantage HMO	Cigna HealthSpring HMO	TexanPlus HMO
Service Area	Brazoria, Chambers, Liberty, Waller, Ft. Bend, Harris, Montgomery, Galveston zip codes - 77510,77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592	Angelina, Brazoria, Cameron, Chambers, Ft. Bend, Galveston zip codes - 77510,77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592 , Harris, Hardin, Hidalgo, Jasper, Jefferson, Liberty, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler, Walker, Waller, Willacy	Brazoria, Chambers, Ft. Bend, Galveston zip codes - 77510,77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592, Austin, Harris, Hardin, Jefferson, Liberty, Montgomery, Orange, Waller
Annual Deductibles	None	None	None
Maximum Annual Out-of-Pocket Costs	\$1,500 for certain services. You will always pay copayments or coinsurance for outpatient prescription drugs, PCP/specialist visits, and other services listed in your evidence of coverage	\$2,500 for certain medical services and Medicare Part B prescription expenses. You will always pay copayments or coinsurance for outpatient prescription drugs, PCP/specialist visits, and other services listed in your evidence of coverage	\$2,500 for certain services. You will always pay copayments or coinsurance for outpatient prescription drugs, PCP/specialist visits, and other services listed in your evidence of coverage
Lifetime Maximum	None	None	None
PCP	\$0 copayment	\$10 copayment	\$10 copayment
Specialist	\$15 copayment	\$25 copayment	\$25 copayment
Chiropractic	\$15 copayment	\$25 copayment	\$25 copayment
Podiatry	\$15 copayment	\$25 copayment	\$25 copayment
Inpatient Hospital	\$300 copayment	\$275 copayment	\$300 copayment
Emergency Room	\$50 copayment	\$50 copayment	\$50 copayment
Ambulance	\$100 copayment	\$100 copayment	\$50 copayment
Urgent Care Center	\$50 copayment	\$40 copayment	\$50 copayment
Lab & X-Ray Diagnostic Radiology	\$0 copayment \$100 for CT, MRI, CNM \$150 for PET scans	\$0 copayment with office visit \$100 for CT, MRI, CNM \$150 for PET scans	\$0 copayment with office visit \$75 for MRI, MRA , CT scan \$150 for PET scans
Therapeutic Radiology (treatment of cancer and other diseases with radiation)	\$15 copayment	\$25 copayment	\$25 copayment
Physical Therapy	\$15 copayment	\$25 copayment	\$25 copayment
Occupational Therapy	\$15 copayment	\$25 copayment	\$25 copayment
Immunizations	\$0 copayment	\$0 copayment	\$0 copayment
Home Health	\$0 copayment	\$0 copayment	\$0 copayment
Skilled Nursing	\$0/day - days 1-20 \$100/day - days 21-100 Covered 100 days per benefit period.	\$25/day for days 1-100 Covered 100 days per benefit period.	\$0/day - days 1-20 \$100/day - days 21-100 Covered 100 days per benefit period.
Renal Dialysis	\$50 copayment per session	\$25 copayment per session	\$50 copayment per session
Durable Medical Equipment	10% coinsurance	10% coinsurance	10% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic Equipment	20% coinsurance	20% coinsurance	10% coinsurance
Diabetic Supplies	20% coinsurance	20% coinsurance	10% coinsurance
Diabetic Monitoring / Training	\$0 copayment	\$0 copayment	\$0 copayment
Diabetic - Injectable Insulin (30-day supply)	See prescription drug benefit	See prescription drug benefit	See prescription drug benefit
Colorectal Screening	\$0 copayment	\$0 copayment	\$0 copayment
Hospice	Covered by Medicare at Medicare-certified facility	Covered by Medicare at Medicare-certified facility	Covered by Medicare at Medicare-certified facility
Well-Woman Exam	\$0 copayment	\$0 copayment	\$0 copayment
Well-Man Exam	\$0 copayment	\$0 copayment	\$0 copayment

Benefit	KelseyCare Advantage HMO		Cigna HealthSpring HMO	TexanPlus HMO
Outpatient Surgery				
Hospital	\$175 copayment		\$200 copayment	\$175 copayment
Ambulatory	\$150 copayment		\$200 copayment	\$125 copayment
Mental Health				
Inpatient	\$300 copayment 190 days lifetime max		\$275 copayment 190 days lifetime max	\$300 copayment 190 days lifetime max
Outpatient	\$35 copayment per session		\$25 copayment per session	\$35 copayment per session
Substance Abuse				
Inpatient	\$300 copayment 190 days/lifetime		\$275 copayment 190 days lifetime max	\$300 copayment 190 days lifetime max
Outpatient	\$35 copayment per session		\$25 copayment per session	\$35 copayment per session
Prescriptions				
Retail	In-network	Out-of-network		
Generic (preferred)	\$10 copayment	\$15 copayment	\$10 copayment	\$10 copayment
Non-preferred Generic	\$30 copayment	\$35 copayment	—	—
Preferred Brand	\$30 copayment	\$35 copayment	\$30 copayment	\$30 copayment
Non-Preferred Brand	\$45 copayment	\$50 copayment	\$45 copayment	\$45 copayment
Specialty Drugs	\$45 copayment	\$50 copayment		
Prescriptions filled out-of-network for KelseyCare HMO will cost \$5 more than in-network. Preferred or network pharmacies are Walmart, Sam’s Club, Kelsey-Seybold and H-E-B.				
Mail Order				
Generic (preferred)	90-day supply for a 3-month copayment (as listed) is provided at the local pharmacy. Kelsey-Seybold pharmacies will mail prescriptions upon request.	\$20 copayment		90-day supply for a 2-month copayment (as listed) is provided at the local pharmacy. No mail order option.
Non-preferred Generic		—		
Preferred Brand		\$60 copayment		
Non-Preferred Brand		\$90 copayment		
Specialty Drugs				
	N/A			
Medicare Part B Drugs	15% until out-of-pocket max = \$1,500 then 100%	15% until medical and Medicare Part B prescription expenses out-of-pocket max. = \$2,500 then 100%		10% until out-of-pocket max = \$2,500 then 100%
Additional Benefits				
Dental	\$0 for Medicare-covered benefits		Discount services (up to 50% for certain services at selected providers)	\$0 for Medicare-allowed services
Vision (routine)	\$0 per annual exam		You pay 100% for routine eye exam. You pay 20% of Medicare-approved amount for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) and Medicare-covered eye wear (one pair of eye glasses or contact lenses after each cataract surgery)	\$25 for 1 routine exam per calendar year 20% of Medicare-approved amount for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) and Medicare-covered eye wear (one pair of eye glasses or contact lenses after each cataract surgery)
Eyewear	\$50 max per year for contact lenses and eye glasses			\$50 max per year for contact lenses and eye glasses
Hearing (routine)	\$15 copayment per annual exam		You pay 100% for routine hearing exam	You pay 100% for routine hearing exam
Hearing aids	Discount up to 20% per year		Discount program provides a discount up to 30% for hearing aids at select providers	\$500 toward the cost of a hearing aid (one every three years)
If there exists a conflict between this Comparison Chart and the official plan documents for each plan, the official plan documents will prevail. The city of Houston reserves the right to change, modify, increase or terminate any benefits.				